Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01		(X3) DATE SURVEY COMPLETED			
			B. WING		R		
		HAL025026	B. WING		04/0	6/2016	
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
RIVERSTONE 104 EFIRD BOULEVARD NEW BERN, NC 28562							
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (X5 (EACH CORRECTIVE ACTION SHOULD BE COMPL		(X5) COMPLETE DATE	
{C 000}	Initial Comments		{C 000}				
	This report is of a F Getchell on April 6,	follow-up Survey done by Bob 2016.					
	The followup survey revealed that all deficiencies have not been corrected, therefore a new plan of correction is required.						
{C 164}	64} Housekeeping and Furnishings-Clean, Repaired		{C 164}		ļ		
	FURNISHINGS (a) Adult care home (1) have walls, ceili coverings kept clea (2) have no chronic (3) have furniture of	es shall: ings, and floors or floor n and in good repair;					
		et as evidenced by: rations, the facility has failed to clean and in good repair.					
		on April 6, 2016 include: ne bathroom of Resident ble at the drain line.					
{C 166}	Housekeeping-Mair	ntained Free of Hazards	{C 166}		ļ		
	FURNISHINGS (a) Adult care home (5) be maintained i orderly manner, free hazards;	06 HOUSEKEEPING AND					

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01			(X3) DATE SURVEY COMPLETED	
			71. 501251110.	••	R		
HAL025026		B. WING	 	04/06/2016			
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
RIVERS	TONE		D BOULEVAI RN, NC 2856				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE	
{C 166}	Continued From pa	ge 1	{C 166}				
	facilities.						
		et as evidenced by: vation, the facility has failed to nd its environment clean and					
		on April 6, 2016 include: r to the Staff Breakroom is					
{C 189}	Building Equipment	Maintained Safe, Operating	{C 189}				
	mechanical, and plu care home shall be operating condition (k) This Rule shall facilities with the ex	11 OTHER d all fire safety, electrical, umbing equipment in an adult maintained in a safe and					
	This Rule is not me 1- Based on observ not maintained safe	rations, plumbing systems are					
	Followup Findings	on April 6, 2016 include:					
	d- The water cooler machines does not	located beside the drink work					
	2- Based on observ	vations, electrical systems are and operating.					
		on April 6, 2016 include:					

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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 104 EFIRD BOULEVARD NEW BERN, NC 28562 [X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCI'S MUST SE PRECEDED BY FULL TAG [COMPLETE TAG [COMPLE	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 (X3) DA COI		(X3) DATE COMP	TE SURVEY MPLETED		
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 104 EFIRD BOULEVARD NEW BERN, NC 28562 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (C 189) Continued From page 2 has no globe. STREET ADDRESS, CITY, STATE, ZIP CODE 104 EFIRD BOULEVARD NEW BERN, NC 28562 ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE (C 189)									
RIVERSTONE 104 EFIRD BOULEVARD NEW BERN, NC 28562 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (C 189) Continued From page 2 has no globe. 104 EFIRD BOULEVARD NEW BERN, NC 28562 (X5) PROVIDER'S PLAN OF CORRECTION (CEACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE) (C 189) Continued From page 2 has no globe.				1		04/0	6/2016		
NEW BERN, NC 28562 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (C 189) Continued From page 2 has no globe.	NAME OF I								
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has no globe.	PREFIX	SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE			JLD BE	COMPLETE			
has no globe. NOTE: Item back ordered from Lowes.	{C 189}	Continued From pa	ge 2	{C 189}					
	(O 109)	has no globe.		(0.109)					

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